The history of internal medicine at Baylor University Medical Center, part 1

JOHN S. FORDTRAN, MD, W. MARK ARMSTRONG, MD, MICHAEL EMMETT, MD, LLOYD W. KITCHENS, JR., MD,† AND BENJAMIN A. MERRICK, MD†*

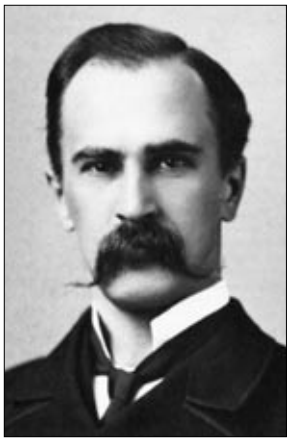

Figure 1. Dr. William Osler in 1881 (age 32), Montreal, Quebec, Canada. Image II-62556 (detail), McCord Museum of Canadian History, Montreal.

DEVELOPMENT OF INTERNAL MEDICINE IN THE USA

Internal medicine in the USA had its roots in the Association of American Physicians (AAP) (1, 2), which was founded in 1885 by a small group of professionally elite physicians who lived along the East Coast (1, 3). These founding members had taken foreign postgraduate study, had interests in clinical research as well as private practice, were skilled in pathology, and were part-time teachers in medical schools (2). The AAP was designed to be a scholarly society in which members could report and discuss experiences and new concepts, but medical ethics and medical politics were excluded (4). At its first meeting, Reginald Fitz gave the first description of appendicitis, and many other major discoveries were first presented at AAP meetings.

A sister organization, the American Society for Clinical Investigation (ASCI), was formed in 1909 by Dr. Samuel Meltzer (5). Its purpose was to develop and promote clinical research. The yearly joint meetings in May of the AAP and ASCI in Atlantic City were, for many years, the highlight of academic medicine in the USA and, indeed, in the world.

Osler and the development of internal medicine

Dr. William Osler *(Figure 1)* was president of the AAP in 1895, and he opened the tenth meeting with a presidential address (4). His remarks are significant because this was the first recorded time that the term "internal medicine" was used in the USA and because he specified his views on the training necessary to practice this specialty that he envisioned:

> The time has come when able young men should be encouraged to devote themselves to internal medicine as a specialty. Content to labor and wait during the first 10 or 15 years of professional life, with pathology as the solid basis of development, such men will pass to the wards through the laboratories thoroughly equipped to study the many problems of internal medicine. . . . The opportunity for such a career is in every city with a hospital of 50 beds.

He elaborated on these concepts in a subsequent essay (6). A reading of Osler strongly suggests that he considered internal medicine to be composed of consultants to general physicians.

Osler was thus proposing that practitioners of internal medicine would spend 10 to 15 years of postgraduate study, much of it in the hospital laboratories of chemistry, physiology, and morbid anatomy (6). Of course, much time should also be spent with patients in outpatient dispensaries and on the wards. Osler considered hospitals to be the college in which medicine could be learned, primarily by practical experience rather than by lectures (6). To a student, he said, "Let the old man read new books; you read the journals and the old books" and, "beware the Delilah of the press, sooner or later she is sure to play the harlot, and has left many a man shorn of his strength, viz., the confidence of his professional brethren." By his prescription, there would be little or no time for love or marriage during the first 10 years of postgraduate study.

The meaning of "internal medicine"

Osler apparently borrowed the term "internal medicine" from the Germans, who began to use it in the 1880s. The *innere* in the German *innere Medizin* is said to have been used to correct the misconception that these special physicians were dealing only with clinical matters, and more specifically was to denote a basis in experimental science (7). If true, this means that the "internal" in internal medicine does not refer to the interior of the body, as usually thought, but rather refers to a physician who gets to the inside of a clinical problem by using knowledge that comes from experimental science. In other words, internal medicine means getting to the underlying basis of the signs and symptoms of an illness, using the experimental method rather than dogma.

From the Department of Internal Medicine, Baylor University Medical Center, Dallas, Texas.

†Deceased.

*Primary authorship is as follows: In part 1, Drs. Fordtran and Merrick wrote about events prior to 1957. Dr. Kitchens wrote about Dr. Tompsett's tenure as chief, and Dr. Armstrong wrote about Dr. Fordtran's tenure as chief. In part 2 (to be published in an upcoming issue), Dr. Armstrong wrote about Dr. Emmett's tenure as chief; Dr. Fordtran wrote about the relationship between Baylor and the University of Texas Southwestern Medical School; and Drs. Armstrong and Emmett wrote about research, medical ethics, and the department's subdivisions.

Corresponding author for part 1: John S. Fordtran, MD, Department of Internal Medicine, Baylor University Medical Center, 3500 Gaston Avenue, Dallas, Texas 75246.

Table 1. Medical specialty boards established by 1940*

	Year of incorporation
1. American Board of Ophthalmology	1917
2. American Board of Otolaryngology	1924
3. American Board of Obstetrics and Gynecology	1930
4. American Board of Dermatology	1932
5. American Board of Pediatrics	1933
6. American Board of Radiology	1934
7. American Board of Psychiatry and Neurology	1934
8. American Board of Orthopaedic Surgery	1934
9. American Board of Colon and Rectal Surgery	1934
10. American Board of Urology	1935
11. American Board of Pathology	1936
12. American Board of Internal Medicine	1936
13. American Board of Anesthesiology	1937
14. American Board of Plastic Surgery	1937
15. American Board of Surgery	1937
16. American Board of Neurological Surgery	1937

*From reference 12.

Although this proposed origin of "internal medicine" is appealing, the name is less clear than those of other specialties, and in some ways, it is unsatisfactory. It often requires an explanation, which is awkward. Even today, it is defined more in negative terms (no pediatrics, no obstetrics, no surgery) than in positive terms. There is confusion between "intern" (from the French *interne*) and "internist." Many have tried to find a better name, without success. Diagnostician (*dia*, through; *gnosis*, knowledge), physician (*physikos*, natural), clinician (*klinikos*, pertaining to a bed), and consultant are other terms that have been suggested or used for physicians in this specialty, but they did not take hold. Considering the evolution of the practice of internal medicine over the past 100 years, "internal medicine" seems better than these other names because it is less restrictive. A name that clearly emphasizes strong ties to medical science and to scholarship would be better, but no such name has been invented.

Despite its uninspiring and confusing name, internal medicine in the USA became powerful in medical schools because of its focus on science, clinical research, and teaching. The identification of internal medicine with the AAP and the ASCI gave the field a lasting academic tone (2). The laboratory and scientific aspects of early internal medicine made the field much more than just a group of doctors who did not do surgery, obstetrics, or pediatrics, and it gave internal medicine a hospital base, such as surgery had.

The American College of Physicians

Internal medicine also became powerful as a practice specialty primarily because of the organizational success of the American College of Physicians (ACP) (2), which was formed in 1915 (8–10). It was patterned after the Royal College of Physicians of London, which was founded in 1518 by a charter granted by King Henry VIII. The Royal College's chief purpose, in 1518 and in the 21st century, is to promote the highest possible standards of medical practice so as to improve health and health care. The purpose of the ACP is to recognize the skills of internists and to advance the field of internal medicine. In 1920, the ACP established a journal called the *Annals of Medicine*, which later changed its name to the *Annals of Clinical Medicine*. In 1927, the journal was renamed the *Annals of Internal Medicine* and today is the most prestigious medical journal devoted specifically to internal medicine.

Board certification

The ACP, in conjunction with the American Medical Association, formed the American Board of Internal Medicine (ABIM) in 1936 (11, 12). The purpose of the board was to establish more definite criteria for the title of specialist in internal medicine, so that the public would know whom to trust. To be certified by the board, an applicant needed to pass rigorous written and oral examinations. Because a sound knowledge of physiology, biochemistry, pathology, and other basic sciences was considered essential for the practice of internal medicine, a portion of the written examination covered these topics in detail. It was decided that no internist would be eligible for fellowship in the college unless he or she had been certified by the examining board. The aim of the college in making this rule was to elevate standards until ACP fellowship had the same connotation as fellowship in the Royal College of Physicians.

Several points are noteworthy about the development of the ABIM. First, the ACP asked the AAP for cooperation in the formation of the board, but the AAP decided that the proposed board was outside the scope of its activity (9). By this decision, academic medicine declined to participate in the certification of internists, perhaps because of its prohibition of medical politics. Second, the board decided that foreign postgraduate training was not a prerequisite for eligibility to take the board examination. Apparently, it felt training in the USA was now on a par with training in Germany, England, and France. Third, the board did not specify where training in the USA should be done prior to taking the board examination. This made it possible for nonuniversity hospitals to offer such training. Finally, as shown in *Table 1*, the ABIM was somewhat of a latecomer to the world of board certification.

In 1940, the ABIM decided to certify candidates as subspecialists in 4 fields—cardiology, gastroenterology, tuberculosis, and allergy—but only if those candidates were first board certified in general internal medicine. Dermatology and neurology had formed their own boards several years before the ABIM was formed, so dermatologists and neurologists could not be compelled to obtain prior certification in internal medicine. Thus, the ABIM was formed in time to include all but 2 medical subspecialties under the umbrella of internal medicine. By contrast, even though the American Board of Surgery was formed only 1 year later than the ABIM, most surgical subspecialties already had their own boards. Therefore, surgery (or general surgery) did not gain control over its subspecialties.

Table 2 provides an additional comparison of the boards of internal medicine and surgery (12). In contrast to surgery, the ABIM had no desire that every practitioner of internal medicine should be board certified and was designed to recognize only a few outstanding internists—a special breed, an outstanding consultant. Therefore, the examination tested not acceptable standards

Table 2. Comparisons of the boards of internal medicine and surgery*

	Internal medicine	Surgery
Date incorporated	1936	1937
Board composition	Two national groups (American College of Physicians and American Medical Association)	Several national and regional groups
Goal	To recognize outstanding internists	To raise the general level of practice: to certify all practicing surgeons
Concern with reimbursement	No	Yes (primarily fee splitting)
Subspecialties	General boards first	Separate boards
Definition of specialty	Not as clear	Reasonably clear

*Modified from reference 12.

of practice but whether the candidate had "superb knowledge of the practice of medicine."

By the time World War II started, the armed services had an easy way to define specialists, i.e., board certification. A board-certified internist became an army captain rather than a first lieutenant (12). While young army doctors might have intended to be general practitioners before the war, afterward many of them quite naturally sought specialty training and certification, often in internal medicine (12).

The trend toward subspecialization

Scientific developments (such as radar, penicillin, and the atom bomb) had made a decisive impact on the outcome of World War II, and it was clear that science would play a similar role in future wars. This mind-set led to the development of the National Science Foundation and the National Institutes of Health (NIH). Through its extramural programs, the NIH poured enormous amounts of money into the internal medicine departments of medical schools (because that's where the best clinical scientists were) (12). The NIH also organized itself into categories based on specific organs and diseases, and this stimulated the trend toward subspecialization. NIH training grants were established, which underwrote the subspecialty clinical and research training of thousands of physicians who were completing a 3-year residency in internal medicine, many having been supported by the GI Bill. Some of these subspecialists entered research-oriented careers (fulfilling the purpose of the training grant), but most went into subspecialty practice. In 1970, the ABIM added subspecialty boards in endocrinology and metabolism, hematology and medical oncology, infectious diseases, nephrology, and rheumatology (and maintained earlier established subspecialty boards in cardiology, gastroenterology, and pulmonary medicine). All of this encouraged internists to subspecialize (12). Moreover, the large amount of money funneled into university internal medicine departments markedly enhanced the image and stature of internal medicine, both in academic medicine and in practice.

Internal medicine today

In the 1950s, there was an interesting dichotomy between internal medicine trainees who planned to go into practice and those who planned to stay in academic medicine and be involved in clinical investigation. Those going into practice were inclined to take their board examination and become a member of the ACP. Those with their sights on an academic career had little inclination to take the board examination. Their goals were to be good teachers, to become members of the AAP and ASCI, and to be promoted to higher grades of professorship. Passing a board examination was not a significant consideration in the promotion process. This changed in the 1980s when agencies that approve residency programs began to downgrade programs in which teaching attendings did not have their board certifications.

Figure 2 attempts to show the enormous evolution of internal medicine in the USA, from its origin in the 1890s to the present time. Starting as a discipline of medicine consisting of a few elite consulting physicians, internal medicine is now in charge of a large part of nonoperative medicine for adults in hospitals and for much of the primary care for adults. Moreover, every certified physician under the umbrella of internal medicine has completed a 3-year general residency in internal medicine, in which he or she is imbued with the scientific spirit, the heritage of Osler, and the need for ongoing scholarship.

It would be hard to imagine a better outcome for internal medicine. Most of the credit goes to its founders in the 1890s who conceived of the then-novel idea of medicine based on experimental science, to the organizational foresight of the ACP, to the high quality of research in university departments of internal medicine, to developments during and after World War II, and to the NIH.

No analytical description, such as this one, can ever explain what it means to be an internist. You have to know some really good internists to be able to appreciate this specialty. Good internists are knowledgeable about all aspects of internal medicine,

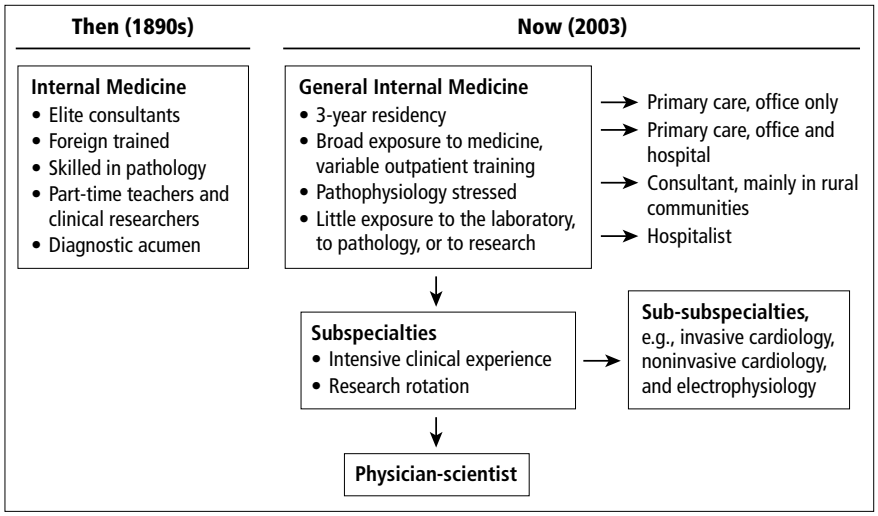

Figure 2. The evolution of internal medicine.

Table 3. Some medical advances for internal medicine during the past century*

1900s	X-rays available in hospitals for diagnosis and later for treatment
1901	Etiology of yellow fever (Reed)
	String galvanometer for electrocardiogram (Einthoven)
1902	Discovery of secretin, the first hormone (Bayliss and Starling)
	ABO blood groups (Landsteiner)
1909	Identification of inborn errors of metabolism (Garrod)
1910	Description of sickle cell anemia (Herrick)
	Goiter caused by iodine deficiency
	Salvarsan for syphilis (Ehrlich)
1911	Virus causes cancer in chickens (Rous)
1912	Mechanism of coronary thrombosis (Herrick)
	Function of the pituitary gland (Cushing)
1915	Discovery of thyroxin (Kendall)
1918	Quinidine for arrhythmias
1920	Injectable mercurials for diuresis
1922	Insulin (Banting and Best)
1925	Parathyroid hormone physiology
1926	Liver for pernicious anemia (Minot and Murphy)
1928	Discovery of penicillin (Fleming)
	Cardiac catheterization
	Pap smear
1929	Electroencephalography (Berger)
1935	Role of kidney in hypertension (Goldblatt)
	Sulfonamides
1938	Electron microscopy
1939	Angiotensin
1940	Rhesus factor (Landsteiner and Wiener)
1941	Treatment of infections with penicillin (Florey)
1944	Streptomycin (Waksman)
	DNA in heredity (Avery)
1945	Plasma protein fractionation (Cohn)
1947	Inhibition of folic acid as therapy for leukemia (Farber)
1948	Cortisone (Hench and Kendall)
1949	Artificial kidney
	Molecular basis of sickle cell disease (Pauling et al)
1950s	Chromosome abnormalities in disease
	Tolerance to foreign tissues (Burnet and Medawar)
1950	Beginning of organ transplantation
1953	Double helical structure of DNA (Watson and Crick)
1954	Aldosterone
1955	Polio vaccine (Salk)
	Warfarin
1957	Ultrasound
1958	Effective oral diuretics
	Cardiac pacemaker
1960s	Clinically successful kidney and liver transplantation (Starzl)
	Treatment of cholera with oral glucose-saline solution
1964	Beta blockers
	Surgeon General's report: Smoking hazardous to health (lung, esophageal, and laryngeal cancer; heart disease; and emphysema)
1966	Genetic code
1967	Computed tomography
1977	Magnetic resonance imaging
1980s	Implantable defibrillators
	Interventional radiology: percutaneous vascular diagnosis, fluid drainage, transjugular intrahepatic portosystemic shunts, stents, embolization
	Successful bone marrow transplantation
1981	Angiotensin-converting enzyme inhibitors
	Cyclosporine for organ transplantation
1982	*H. pylori* as cause of peptic ulcer disease
1985	HIV as cause of AIDS
1988	Statin drugs
1990s	Acute treatment of heart attacks with angioplasty, thrombolytics, and emergency surgery
	Immunomodulators for autoimmune disease
	Hemoglobin A_{1c} testing, home glucose monitoring, and new insulins for diabetes
1997	Cloning
2001	Human genome

*Compiled with the assistance of Drs. Marvin J. Stone and Joe Rothstein. Advances prior to the 1960s were taken mainly from reference 8.

have an uncanny ability to diagnose an acute or chronic medical problem, know when to ignore extraneous information and when to order the decisive test, and have a primary commitment to their patients. Making a lot of money is not a concern of such internists, and they are not jealous of doctors in other specialties who often become relatively wealthy. They take pleasure in acknowledging the fact that they could not practice good internal medicine without outstanding support from radiologists, pathologists, medical subspecialists, and surgeons. Theirs is a lifetime of study, and this is something their patients and colleagues never see, so it remains unappreciated. They care deeply for their patients, sharing both the good and the bad. They communicate effectively and promptly with their patients and thereby relieve anxiety. Their appearance and demeanor reflect the attributes of character described above, best demonstrated by the respect and empathy shown to their patients. They are part of the conscience of the institutions where they work. Most good internists, by this description, are generalists, but subspecialists can also be outstanding internists.

EARLY INTERNAL MEDICINE IN TEXAS

Although increasing numbers of physicians came to Texas in the late 1880s, probably none of them considered themselves internal medicine specialists. These physicians had medical diplomas from various sources. Some were acquired or amplified by apprenticeship to an established practitioner, called "reading" medicine, which focused on studying anatomy, perhaps an early forerunner of an internship but without preceding college studies. Other physicians bought certificates from "bogus" medical schools that sold these documents with little or no instruction. But some physicians had medical diplomas from reputable out-of-state schools, and a few had degrees from the lone Texas medical school, established by the University of Texas in Galveston in the 1880s.

By modern standards, medicine was relatively primitive in the Texas of the last half of the 1880s, for it was still a frontier state. The average practitioner starting his practice went mostly to the villages and small towns, many no longer on the map, for that was where the majority of Texans lived. They treated patients with pneumonia, diphtheria, malaria, smallpox, dysentery, typhoid,

hookworm, strokes, and other diseases that internists treat today, but these early practitioners also delivered babies, treated children, set broken bones, and occasionally did kitchen-table surgery. Their therapeutic armamentarium was limited. Some procedures dated back many centuries, such as bloodletting, accomplished by venisection or leeches. Also used were cupping, poultices, and counter-irritation, although effective drugs such as quinine for malaria and opiates for relief of pain were available. Despite these limitations, early physicians were held in relatively high esteem by their patients, even though Dr. Osler had made the statement that the physicians of the 1880s did not, and did not pretend to, cure more than 4 or 5 diseases.

The 20th century was a time of rapid advances in medicine, including better methods of diagnosis, new medications, new instruments, and better procedures *(Table 3)*. However, even into the 1920s and 1930s, meticulous diets were the mainstay of treatment for seriously ill patients. A hospital kitchen in the 1930s offered more than 50 specific diets for various diseases. In retrospect, it has been estimated that it was not until sometime between 1935 and 1945 that, for the first time, an American patient seeing an internist could expect safe and efficacious treatment (13).

From our present perspective, it is amazing how innocuous cigarette smoking was considered in the first half of the 20th century. Almost half of Baylor medical students in the late 1930s smoked. Not even mentioning smoking, the 1935 *Cecil's Textbook of Medicine* theorized that emphysema might be the result of premature calcification of the costal cartilages or of thoracic intervertebral disc disease. Cigarette advertising was pervasive. Ads told women cigarettes would keep them thin, and their under-10 daughters "smoked" candy cigarettes, imitating parents and glamorous Hollywood stars. Members of the US Armed Forces were issued a carton of cigarettes every 2 weeks, whether they smoked or not. During the 1940s, the *Journal of the American Medical Association* had full-page advertisements for Camels and Philip Morris cigarettes. Not until the Surgeon General's report in 1964 was smoking given serious consideration as a health risk, although Ochsner and DeBakey in 1937 reported the removal of lung cancers from 7 patients, suggesting cigarettes as the likely cause of the cancers in all 7.

INTERNAL MEDICINE AT BAYLOR, 1903–1943

The Texas Baptist Memorial Sanitarium was founded in 1903; it was the predecessor of Baylor Hospital (1920), Baylor University Hospital (1936), and Baylor University Medical Center (1959). In the early years of the institution, the focus was on medical education and serving the faculty and students of the Medical Department of the University of Dallas.

The Medical Department of the University of Dallas was organized in 1900 by a group of physicians in Dallas, spearheaded by Dr. Charles M. Rosser, an eloquent speaker and a persuasive person. There was no "University of Dallas." The organizers later obtained an affiliation with Baylor University so that there was a true university connection; at that time, the school's name was changed to Baylor University College of Medicine. The Medical Department had 17 graduates in its first graduating class of 1901. It was destined to continue its existence, unlike other start-up medical schools in Dallas and Fort Worth in the early 1900s (14, 15).

Although the concept of internal medicine as a specialty began on the East Coast in 1895, internal medicine had a slow beginning in Dallas and probably in the rest of the USA. Between 1900 and 1920, only 11 faculty members of Baylor University College of Medicine had titles suggesting an affiliation with internal medicine. In 1914, the medical school began using the faculty designation "professor of internal medicine." Before then, it had noted that faculty members taught "principles and practice of medicine," using the title of Osler's textbook.

Figure 3. Dr. Clarence Grigsby, chief of internal medicine at Baylor Hospital from 1912 to 1928.

Three of those affiliated with internal medicine had relatively long tenures, including Clarence M. Grigsby (1912–1942), Raleigh W. Baird (1918–1927), and Homer Donald (1920–1943) (15). The extent to which these men functioned as internists, as defined by the standards described above, is unknown. Drs. Baird and Grigsby were considered prominent Texas internists between 1905 and 1925. Dr. Grigsby *(Figure 3)*, who was chief of internal medicine at Baylor from 1912 to 1928, was a governor of the ACP and is remembered by those who went to medical school at Baylor in the late 1930s. His postgraduate study in internal medicine consisted of repeat visits at Johns Hopkins, Chicago, New York, Boston, London, Scotland, and France. Between 1921 and 1943, 28 additional medical school faculty members had titles indicating a primary interest in internal medicine (15), and they presumably practiced internal medicine in Baylor Hospital.

An internship program was started at Texas Baptist Memorial Sanitarium in 1910. Drs. B. B. Brandon and James Halbert Gambrell were Baylor's first interns, according to records in the Baylor medical education department. As time went on, the number of interns per year increased. For example, in 1921 there were 13 interns.

Dr. Henry M. Winans

From 1920 through 1943, Henry Morgan Winans was Baylor's and Dallas' most prominent and most influential internist *(Figure 4)*. Dr. Winans was born in 1894 and was a native of Denver, Colorado. He graduated from Stanford University in 1916 and from Johns Hopkins Medical School in 1919. During his senior year at Hopkins, Dr. Winans was introduced by a private patient to a nursing student, Judith Terrell Hawley, who was from Fort Worth, Texas. Their first meeting had to be in secret, because nursing students were not allowed to be seen with medical students or doctors. The two students were married within a period of only about 8 weeks. Upon his graduation from medical school in 1919, they moved to Fort Worth, and a year later, they moved to Dallas. On May 17, 1920, Dr. Winans gained membership in the Dallas County Medical Society, on the same night when society members met to discuss the closure of the Texas Baptist Memorial Sanitarium to all physicians who were not on the faculty of Baylor University College of Medicine (14).

Dr. Winans became an instructor in the medicine department of Baylor University College of Medicine. Simultaneously, he

Figure 4. Dr. Henry M. Winans, chief of internal medicine at Baylor University Hospital from 1929 to 1940 and 1947 to 1956.

began a private practice of internal medicine. At the school he was rapidly promoted, and in 1929 he became a professor of medicine and head of the department of medicine. He was elected to fellowship in the ACP.

Dr. Winans' first office for private practice, in 1920, was located in the Medical Arts Building. He is said to have been the first physician to leave that building and move his office to a house in the Oak Lawn area. Many others followed. He was the head of a clinic on Oak Lawn that mainly consisted of internists, but also contained at least one surgeon and a psychiatrist. One of the internist members of Dr. Winans' clinic was Dr. Walter Moursund, dean of Baylor University College of Medicine from 1920 to 1943. Dr. Winans was very punctual. When a patient's hour of consultation was up, the consultation would end, abruptly if necessary, so that he could see the next patient on time. Dr. Winans kept careful records on his practice and would give lectures or write articles about his office experience.

Although he visited his patients when they were in the hospital, he apparently was not very active in hospital practice. His younger associates from his clinic, including Drs. Ben Merrick, Carey King, and Henry Winans, Jr., provided most of the care for his patients when they needed to be hospitalized.

Whether in the office, medical school, or hospital setting, Dr. Winans had a formal and scholarly appearance. He usually wore a vest, with his Phi Beta Kappa key displayed. He was driven to and from his office or Baylor by a chauffeur, as he read medical articles in the backseat. He got up at 4:30 AM to dictate and read.

Dr. Winans was broadly read in several areas other than medicine. He wrote 3 novels, which were not published but which have been preserved. He also wrote 2 articles in *Harper's* magazine about flying. In the *Dallas Morning News*, he published articles on a broad range of topics, including the growing of mushrooms and the care of the aged. He also wrote book reviews. It was said that his magic word was "work." After having received many honors, he died in March 1965, at the age of 71. The day before his death, he put in a full day at his office, seeing patients.

Teaching program and attending physicians

Dr. Winans started a residency training program in internal medicine at Baylor Hospital in the late 1920s, at approximately the same time that residency training in internal medicine was started in Galveston (16). These were the first such training programs in the state. Several of his lectures to medical students have been preserved (from wire spool recordings typed by his wife). Many of them dealt with "minor medicine," such as headache, insomnia, and indigestion, which he said was minor to doctors but not to patients. He often lectured on medical history. He led grand rounds at Baylor every Sunday from 8:00 to 9:00 AM. In attendance were students, housestaff, and attending physicians. Dr. Winans was outstanding at case discussions and at electrocardiography. He authored 32 publications in medical journals.

Figure 5. Dr. Ben Merrick, a resident at Baylor Hospital in the 1930s and a practicing internist at Baylor for many years.

Dr. Ben Merrick *(Figure 5)*, a student and resident in the 1930s who became a revered medical historian and physician (17), recalled a number of details of life as a resident in that early period. Interns were paid $25 per month; junior residents, $35 per month; and senior residents, $50 per month. They also received room and board in a 2-story frame house facing Gaston Avenue. Interns and residents followed senior internists on their ward rounds. In addition to formal grand rounds, unknown case conferences, and symposia, many informal sessions were held with the chief hospital pharmacist, Lewis S. Smith. Residents learned about the drugs of the era, many still compounded in grains, minims, and ounces. On one of his vacations, Dr. Merrick helped out a country doctor: assisting in appendectomies; giving injections, often of thiamine or sodium cacodylate, to those complaining of chronic fatigue; and making house calls, during which he diagnosed diseases like malaria and oculoglandular tularemia. The diagnosis of malaria was verified from a blood smear made on a piece of broken window pane at the home.

Dr. E. R. Hayes was a student at Baylor University College of Medicine in the late 1930s. His most vivid impression of Baylor Hospital and its medical staff was the dedicated volunteer physician teachers and the care they provided to indigent patients in the Baylor charity clinic. They worked one-on-one with medical students. Interns and residents were busy in the hospital and did not work in the clinic. Dr. Hayes in particular remembered the following men: Drs. Gordon Maddox, Charles Shuey, Sr., Louis Allday, Sr., J. Shirley Sweeney, David Carter, John S. Bagwell, Richard Dathe, Milford Rouse, Cecil Patterson, Frank Carmen, R. W. Baird, Edward Rippey, John Minnett, Tate Miller, E. M. Mendenhall, and Sam Shelburne.

Dr. Hayes said these men worked so hard on charity cases and on the teaching of students because they wanted the hospital and the school to excel, and because working with students in the charity clinic enhanced their stature within the hospital and in the community. Furthermore, most of these men were not very busy in their practices, and seeing clinic patients with students sharpened their diagnostic skills. He said few, if any, of these men used the term internist. They referred to themselves as diagnosticians.

World War II

In 1940, in response to the War Department's request, Dr. Winans organized Baylor's World War II hospital unit, the 56th Evacuation Hospital, its medical officers largely his ex-students. In 1942, Dr. Winans left a large private practice to activate the hospital, and after a year of stateside training of its personnel, he accompanied the unit for overseas duty in North Africa and Italy.

In the absence of Dr. Winans, the residency program continued under the direction of Dr. Alexander W. Terrell. Dr. Terrell had graduated from the University of Pennsylvania in 1934 and completed residency training at the hospital of the University

of Pennsylvania from 1934 until 1938. In 1939, he was an instructor in both medicine and pharmacology at the University of Pennsylvania. He moved to Dallas in 1939 and obtained his board certification in internal medicine in 1943. Dr. Terrell was a superb and dedicated teacher and clinician, but unfortunately he had severe hypertension, which was more or less untreatable in the 1930s and 1940s. He died of a stroke in 1949, at age 41.

Dr. Arvel Haley was an intern at Baylor during this period, in 1942–1943. He cited Dr. Terrell and other outstanding teachers including Drs. Al Harris and Paul Thomas. He said that he chose Baylor because it had an excellent reputation, especially among Baylor University College of Medicine graduates.

INTERNAL MEDICINE AT BAYLOR, 1943–1957

Internal medicine at Baylor University Hospital changed when the medical school moved to Houston in 1943.

The move of the medical school followed a chain of events (14, 15). Dr. E. H. Cary was dean of Baylor University College of Medicine from 1902 until 1920. In 1939, after being away from the medical school for 19 years, he formed the Southwestern Medical Foundation. He said that the purpose of the foundation was "to support research in medicine, to bring Dallas and Texas to the stature enjoyed by Johns Hopkins, Cornell, Northwestern, and Mayo Foundation." He thought that under the present arrangement, Baylor University College of Medicine would not accomplish much research. The foundation tried to raise money for an endowment for research at the medical school, but the response to this effort was not encouraging. Dr. Cary thought that Baylor was a "sectarian" institution and that this impeded philanthropic giving. He thought, and he was right, that there was minimal financial support from Baylor University in Waco. He also criticized a lack of research by the faculty.

The Southwestern Medical Foundation initially proposed that the school be moved to the Parkland campus. Although an agreement was signed with Baylor University to do just that, disputes over control became bitter. Finally, Baylor contracted with the M. D. Anderson Foundation, and a deal to move the medical school to Houston was quickly made.

Southwestern Medical School was founded in 1943 in Dallas to replace the Baylor school. (It became the University of Texas Southwestern Medical School [UT Southwestern] in 1949.) Some students and faculty moved to Baylor in Houston; others stayed in Dallas with the new school. The hostilities did not greatly affect students, faculty, or Dallas doctors. While the Baylor College of Medicine was in Dallas, physicians interested in internal medicine often selected Baylor Hospital for their patients because of the academic affiliation with a medical school. They were involved with the school as much as they were involved with the hospital. For them, it was easy and natural to become aligned with UT Southwestern after the Baylor school departed. In fact, they were rapidly amalgamated into the clinical teaching faculty at Southwestern.

Although Baylor doctors easily survived removal of Baylor University College of Medicine, the departure of the medical school was catastrophic for the department of medicine at Baylor University Hospital. The Texas Baptist Memorial Sanitarium was founded mainly in response to the needs of the medical school, and the running of internal medicine within Baylor University Hospital was under the direction of physicians appointed by the medical school. All of the hospital's physician management structure must have quickly disappeared when the medical school moved away. So, at the end of World War II, the internal medicine department at Baylor Hospital was in disarray. There was no plan for the continuation of the residency program; there were no chairmen of the various departments. In addition, the physicians who returned from the armed services thought that the physicians that had been added to the staff during the war were not up to standards and that the medical staff needed to be "cleaned up." They petitioned the board of trustees to appoint the "best" physician in each department to be chief and to lead in this "cleanup." Dr. Winans was the natural selection for internal medicine.

Closing of the medical staff

Many veterans went to medical school after the war with support from the GI Bill. A large number of them finished medical school in the late 1940s, and this resulted in a large influx of applicants for medical staff privileges at Baylor. Many of the applicants were board certified in internal medicine. By 1950, there were over 40 board-certified internists on the Baylor medical staff, and the number continued to increase.

Truett Hospital opened in 1950. It was the only air-conditioned hospital in the city. This, and the other modern features of Truett, brought much attention to Baylor, not the least of which was the image of a "specialty" hospital. All of this resulted in a further increase in the number of physicians applying for staff privileges, in many instances by well-established physicians at other Dallas hospitals that did not have Baylor's specialty image.

By 1954, even doctors on the teaching services at Baylor could not get their patients into the hospital. Waiting periods were 3 to 5 weeks for elective admissions; in contrast to today, patients were admitted for days to weeks in the 1950s. Private rooms were almost impossible to obtain. The pressure to do something was enormous, and the two "solutions" were to build Hoblitzelle Hospital (which would take time) and to decrease demand by putting a moratorium on the addition of new physicians to the medical staff.

The moratorium had disastrous effects. Among the medical staff, it created intense rivalries as a few physicians were forced out by other more powerful physicians, and many more feared they would lose their privileges. In time, the moratorium created a generation gap—with old and young physicians but none in the middle-age range.

In response to the desire of some prominent Baylor physicians to add partners, the moratorium was relaxed after about a year. New partners of attending physicians could join the staff in some departments (but not others). But lasting damage had been done. The partial moratorium was variably enforced after Hoblitzelle Hospital opened in 1959. In internal medicine, it was apparently still in force in 1966, when Dr. Dan Polter applied for privileges but was rejected. Even 20 years later, the rumor persisted that new staff were not welcome at Baylor.

Intern and residency programs

From 1943 until the mid 1950s, Baylor administrators and medical staff accepted that the internship and residency programs at Baylor would play second fiddle to those at medical schools. Graduating Baylor residents could not get staff privileges at Baylor,

Figure 6. Dr. Paul Thomas, chief of internal medicine at Baylor University Hospital from 1956 to 1957.

which made it hard to recruit interns and residents. Interns and residents were often used for "scut" work. In 1946, when Dr. Elgin Ware was an intern, all of Baylor's interns went on a 24-hour strike to protest the lack of teaching. Nevertheless, both the administration and physicians wanted a postgraduate program. According to David Hitt, Boone Powell, Sr., was intensely supportive of medical education because he thought it would improve the standards of practice in Baylor, more so than anything he could impose on the medical staff in the way of continuing education. Although the administration supported medical education in theory, Baylor physicians involved with the teaching programs felt there was little monetary support.

In September 1950, Dr. LeRoy Kleinsasser, chief of surgery at the Lisbon Veterans Administration (VA) Medical Center, accepted the position of director of the intern and residency training programs at Baylor. He probably was the first physician who was paid a salary for teaching in Baylor Hospital, and the small salary he received was resented by some if not many of the attending physicians.

Dr. Kleinsasser had this job for 3 years, and he realized that he was not succeeding in improving the residency programs. There was a shortage of interns nationally, and competition for the good students was intense. Baylor interns received lower salaries than interns at other institutions. The money allocated to the teaching budget was strictly limited, and it included salaries for housestaff as well as for the care of clinic patients. Even the provision of uniforms was contentious. The residents were spread very thin and had to rotate through the emergency department, which was unpopular. On several major services, all attendings insisted on resident coverage of all of their patients, which made it impossible to have a real teaching program for the residents' benefit. Although the names of interns and residents at Baylor during this period of time are available, apparently none joined the medical staff at Baylor or practiced internal medicine in Dallas.

Dr. Paul Thomas, chief of internal medicine at Baylor University Hospital

As already mentioned, the internal medicine department at Baylor was not doing well in the 1940s and early 1950s. Dr. Winans was still chief of medicine, and in 1956 he asked Dr. Thomas to replace him as chief of internal medicine *(Figure 6)*.

Paul Jasper Thomas was born in New Mexico on September 21, 1910. After only a few months he moved with his parents to Pine Forest, near Sulphur Springs. He attended the public school in Pine Forest, but he also had a private teacher in public speaking. In 1924, the family moved to Dallas, and he attended schools in the Park Cities. He attended Southern Methodist University and then Baylor University College of Medicine, from which he graduated in 1936. He did a 2-year rotating internship at the City-County Hospital in Binghampton, New York. He then did an internal medicine residency at Charity Hospital in New Orleans, on the Tulane service (where his father had graduated from medical school in 1899). At the end of his third year of residency, he was appointed assistant clinical director in medicine at Charity. He held that position for a year, and then World War II started. He had been in the reserve but had been dropped in 1941 because of peptic ulcer disease.

Figure 7. Dr. Ralph Tompsett, chief of internal medicine at Baylor University Medical Center from 1957 to 1979.

Dr. Thomas moved to Dallas in 1942, where he quickly became busy making house calls, covering the whole county. He was on the teaching service at Baylor and later UT Southwestern, at Parkland Hospital, St. Paul Hospital, and at Methodist Hospital. His primary hospital for his own patients was always Baylor, although Baylor beds were often scarce. Sometimes he had patients at 6 hospitals at the same time (Baylor, Medical Arts, Gaston, St. Paul, Methodist, and Parkland). He made many house calls, which always preceded sending a patient to the emergency department. He spent 1 to 3 hours a day on the telephone talking to patients about something that had been done in the office or about a problem they were having. A large percentage of those phone calls were related to epidemic enteric and respiratory diseases.

Dr. Thomas was an outstanding internist, and he was fun to be with. Known as "Brownie" by his friends, he was the physician to many other Baylor doctors and their families. His keen intellect and wit made him a stimulating clinician, teacher, and colleague. He was the conscience of the department of medicine at Baylor in its pursuit of excellence as a teaching institution and in providing quality medical care for Baylor patients. Dr. Thomas taught on the teaching services of Baylor and Parkland Hospitals until his 70th birthday. He then continued to teach students, interns, and residents on his private patients at Baylor until he retired; he died in March 1995.

When Dr. Thomas agreed to become chief of medicine at Baylor in 1956, he had a vision for Baylor. He thought that Boston was the greatest medical city in the USA, and he hoped that Dallas could become like it. Specifically, he wanted all of the leading hospitals to become coordinated into an excellent teaching program, using UT Southwestern in the way that Harvard is related to Boston's major hospitals. He wanted Baylor to have hospital-based physicians to help generate teaching and research, as well as an active attending staff. As the new chief of medicine, he immediately began the search for his replacement, whom he wanted to be a full-time chief, an individual with impeccable academic, research, and medical literary credentials who was also an excellent and experienced clinician who could interact effectively with the private practice community.

THE TOMPSETT YEARS

When recruitment for the full-time chief of internal medicine at Baylor began, Dr. Ralph Tompsett was attracted to the position, but he and wife, Jean, a registered nurse, were both natives of the Northeast and were reluctant to leave New York City. However, Dr. Thomas and Boone Powell, Sr., were persistent and persuasive,

Figure 8. Dr. John W. Hyland, the first hospital-based subspecialist who taught cardiology and the first director of the H. L. and Ruth Ray Hunt Heart Center.

and at last Dr. Tompsett relented and agreed to accept the challenges and opportunities of the position *(Figure 7)*. Upon his relocation to Dallas, Dr. Tompsett was named a full professor of internal medicine at UT Southwestern.

Dr. Tompsett had served as a chief of a field hospital (actually a MASH unit, or medical and surgical hospital) in the South Pacific during World War II, where he had carried out early investigations in the treatment of spirochetal diseases with the revolutionary new agent, penicillin. After the war, he traveled to a Native American reservation in the American West, where he carried out early trials of isoniazid therapy of endemic miliary tuberculosis.

Returning to New York, his attention turned to infective endocarditis (then called subacute bacterial endocarditis). He developed the first curative regimen for enterococcal endocarditis, a combination of penicillin and streptomycin, which was standard treatment for the condition for at least 30 years.

Dr. Tompsett's leadership and integrity and the respect in which he was held allowed him to develop a program of full-time, primarily in-house chiefs of the various subspecialties of internal medicine. The first such individual was Dr. John W. Hyland in cardiology *(Figure 8)*, followed by Dr. Daniel E. Polter in gastroenterology, Dr. Zaven H. Chakmakjian in endocrinology, Dr. Charles E. Jarrett in pulmonology, Dr. Sheff D. Olinger in neurology, and Dr. Merrick H. Reese in hematology/medical oncology, among others. With the development of formal subspecialty divisions came the establishment of fellowship programs in several fields.

Soon after arriving at Baylor, Dr. Tompsett established what over the years became a strong and cherished tradition of medical grand rounds each Tuesday morning at 8:00. These exercises present outstanding continuing education opportunities and are enthusiastically attended by the medical staff, including junior students and division chiefs.

In addition, Baylor's strong association with UT Southwestern continued and was strengthened during Dr. Tompsett's tenure, with at least one fourth of UT Southwestern's junior students serving a large portion of their internal medicine rotation at Baylor.

Working closely with Dr. Merrick H. (Mike) Reese, then director of Baylor's internal medicine intern and residency program *(Figure 9)*, Dr. Tompsett quickly built the medicine training program at Baylor into a well-known and much-sought-after program. Dr. Reese was responsible for recruitment of prospective interns primarily from regional medical schools, where he would visit to meet, evaluate, and recruit selected senior medical students. This time-consuming recruitment proved quite successful. A measure of its success is that over the years the first-time successful completion rate by Baylor's medicine trainees on the ABIM certifying examination approached 100%. As Baylor developed a reputation for an excellent housestaff program, it began to receive more

Figure 9. Dr. Merrick Reese, director of the internal medicine residency program for 15 years.

outstanding applicants from superior schools than it could accommodate. Dr. Reese deserves much of the credit for this spectacular turnaround.

Mr. and Mrs. I. A. Victor, who were patients of Dr. Hyland, were strong financial benefactors for the internal medicine department. They provided the rehabilitation unit for the Heart Center. In addition, they supported a library for internal medicine houseofficers that they named in honor of Elias Strauss, MD.

Oral surgery liaison

In 1973, D. Lamar Byrd, DDS, MSD, long-time chief of oral surgery at Baylor College of Dentistry, and Dr. Tompsett agreed on a plan whereby the chief oral surgery resident would work for 6 months with a senior internal medicine resident. The first oral surgery resident to participate in this novel program was Arlet Dunsworth, DDS, MSD. For over a quarter century, dozens of young oral surgeons have benefited from Dr. Byrd's and Dr. Tompsett's vision and willingness to be innovative. By the same token, a generation of medicine residents have profited from the "cross-fertilization" that resulted from working closely with their contemporaries in a different yet related professional discipline.

Baylor and the American College of Physicians

Dr. Tompsett brought his enthusiasm for the ACP to Baylor. Serving as ACP governor for northern Texas from 1970 until 1977, Dr. Tompsett was instrumental in establishing the ACP's program of nationwide postgraduate courses. After his governorship, Dr. Tompsett was elevated to ACP regent and finally to national vice president.

Dr. Tompsett continually encouraged his trainees to become active in the ACP and ensured that all his residents became ACP associate members, finding funds in his limited budget to pay their ACP dues. ACP associate membership allowed them access at reduced prices to ACP courses, meetings, and the most respected and widely used study guide for the ABIM certifying examination, the ACP's *Medical Knowledge Self-Assessment Program*.

With Dr. Tompsett's support and encouragement, a number of Baylor physicians have served in ACP leadership positions, including Drs. Albert D. Roberts (governor, regent, and vice chair of the board of regents), Marvin J. Stone (governor), F. David Winter (governor), Lloyd W. Kitchens (governor and regent), and W. Mark Armstong (governor-elect). A number of Baylor physicians have held positions of leadership in the Texas Academy chapter of the ACP. Baylor physicians elected to the college's highest honor, mastership, are Drs. Tompsett, Roberts, Stone, Kitchens, John Fordtran, and Michael Emmett.

In addition to the ACP, Baylor's internists have devoted much time to civic and professional organizations. Drs. David W. Carter and Edwin Rippy became presidents of the Dallas School Board, and a Dallas high school bears the name of Dr. David Carter. Dr. Everett Fox served on the Dallas City Council. Dr. Milford Rouse became president of the American Medical Association in 1967,

Figure 10. Dr. John S. Fordtran, chief of internal medicine at Baylor University Medical Center from 1979 to 1996.

an honor accorded to Dr. Edward H. Cary earlier. Baylor's internists often joined nationally recognized speakers in presenting papers at the annual Dallas Southern Clinical Society's Spring Conference from its inception in 1929. Eleven Baylor internists have served as president of the Dallas County Medical Society.

THE FORDTRAN YEARS

Dr. John S. Fordtran succeeded Dr. Tompsett as chief of internal medicine in 1979 *(Figure 10)*. Dr. Fordtran is a native Texan; he grew up in Stockdale, a small town in South Texas, and worked on his parents' farm. He left the small town for his high school years at Texas Military Institute in San Antonio. His college career was spent at the University of Texas at Austin, where he completed his premedical training in 3 years. He went to medical school at Tulane Medical School, earning his medical degree in 1956.

Dr. Fordtran first came to Dallas to serve his internship and residency at Parkland Memorial Hospital under Dr. Donald W. Seldin, who persuaded him to do a fellowship in gastroenterology in order to return to UT Southwestern, which had no full-time gastroenterologist at that time. After his residency, he served 2 years in the Public Health Service—1 year at the NIH and the second as chief medical officer at the Fort Defiance Indian Hospital in Arizona. At the end of this tour of duty, Dr. Fordtran trained at Massachusetts Memorial Hospital in Boston with Dr. Franz Ingelfinger, the nation's preeminent gastroenterologist. After completion of his fellowship, he returned to UT Southwestern to join the internal medicine faculty under Dr. Seldin.

Dr. Fordtran became the chief of gastroenterology and a professor of medicine at UT Southwestern. He was involved in major research efforts, particularly in the fields of ion transport physiology, diarrhea, malabsorption, and peptic ulcer. He coedited the most important textbook in gastroenterology, entitled *Gastrointestinal Diseases: Pathophysiology, Diagnosis, and Management*. In 1977 he was president of the American Society for Clinical Investigation. His training program was considered to be equal to any in the USA, attracting both research and clinical faculty and fellows.

In 1979 Dr. Dan Polter, Dr. Billy Oliver, David Hitt, and Dewey Presley recruited Dr. Fordtran to move to Baylor as chief of internal medicine.

The internal medicine department when Dr. Fordtran came to Baylor

When Dr. Fordtran arrived at Baylor, he found that many subspecialists had been recruited to Baylor to form a hospital-based department. The head of each subspecialty unit was paid a stipend by the hospital, and all hospital-based subspecialists had their office provided to them. These subspecialists had a strong positive impact on the teaching program, but many physicians in the medicine department who were not hospital based, yet who were also involved with the teaching program, did not think this arrangement was fair—except when hospital-based physicians were doing something special, such as research.

Dr. Fordtran felt that the leadership in the department should be more inclusive of general internists. He believed that the broad perspective of general internists would help balance the more narrow concerns of increasingly diverse subspecialists. Throughout his tenure, Dr. Fordtran made several critical moves to raise the visibility of the general internist at Baylor.

The medical advisory committee had been established before Dr. Fordtran's arrival. However, this committee did not meet regularly and was not perceived as an important committee at Baylor. He wanted a stronger committee to help with some difficult decisions that would need to be made. The committee began meeting monthly, and the composition of the committee reflected both subspecialists and general internists *(Figure 11)*. The committee gave feedback to Dr. Fordtran regarding problems or controversies occurring throughout both the Department of Internal Medicine and Baylor in general. Formerly, members of the medical advisory committee had been appointed, but Dr. Fordtran decided to have formal elections by the department at large to choose the representatives. As the medical advisory committee became more important, it functioned as an "executive committee" for the Department of Internal Medicine.

Internal medicine residency program

Before he came to Baylor, Dr. Fordtran knew very little about the internal medicine residency program at Baylor. Once he arrived here, he quickly decided that the program could be an outstanding one and, in fact, could be the best internal medicine program in Texas. He set out to achieve that goal. He was able to find committed internists, both specialists and generalists, who were interested in teaching. He emphasized the commitment to teaching, and if the attendings were not living up to their responsibilities, they were not invited back to participate in the teaching program. If attendings admitted patients to the teaching service but did not allow the residents sufficient autonomy, he would not allow those physicians to admit patients to the teaching service.

It was propitious that shortly after Dr. Fordtran arrived at Baylor, the administration and medical board were developing several tasks forces, including one to champion education. Sparkey Beckham was the trustee assigned to this task force, and he recognized that education was essential to the mission of Baylor. One of the outcomes of this task force was that the housestaff was able to get excellent facilities in the newly constructed Roberts building. Well-appointed overnight call rooms were built, and study areas where each resident has a carrel were constructed. The medical education office and outpatient clinic were placed in the same geographic area. This facility was a good recruiting tool, as prospective housestaff members could see their sleeping quarters, study rooms, and medical education office when they interviewed for residencies at Baylor.

In 1989 the internal medicine teaching facilities were markedly improved by a generous gift from the family of Dr. John S. Bagwell, one of Baylor's outstanding general internists for many years. The original gift from the Bagwell family was to establish the John Spurgeon Bagwell Library for Internal Medicine, in space immediately adjacent to the medical education classroom. Subsequently, Virginia Bagwell donated money on a yearly basis

(a) Left to right: Russell Martin, Howard McClure, David Winter, Ralph Tompsett, John Fordtran, John Binion, Wilson Weatherford, Stuart Owen, Paul Neubach, and Marvin Stone.

(b) Seated: Michael Emmett, John Fordtran, John Binion, and Martin (Buddy) Hurst. Standing: Mark Armstrong, Charles Gottlich, Randlow Smith, Richard Merriman, Paul Madeley, John Pippin, and Michael Highbaugh.

(c) Seated: Elizabeth Polanco, John Fordtran, Sherrie Watkins (head of nursing for internal medicine), and Michael Emmett. Standing: Paul Muncy, Mark Armstrong, Robert Rosen, Randlow Smith, Richard Merriman, Steve Paulson, Weldon Smith, and Robert Baird.

(d) Seated: Melissa Carry, Sue Bornstein, Amy Anderson, and Michael Emmett. Standing: Mark Armstrong, Ken Ausloos, Daniel DeMarco, Alan Martin, and Randlow Smith.

Figure 11. Medical advisory committee members through the years.

for the addition of medical journals, textbooks, and computers. The library was an essential element in the ascendancy of the internal medicine teaching program at Baylor.

Two other general internists contributed in special ways to the teaching program. For many years Dr. Herman Ulevitch gave an elaborate dinner-dance at the Chaparral Club for all Baylor housestaff and for Baylor teaching attendings. In addition, Dr. and Mrs. E. R. Hayes hosted a yearly dinner party in their home for all internal medicine residents and their spouses. These events fostered camaraderie and friendship, and they added to the pleasure of being a Baylor resident or attending physician.

Dr. Fordtran found another friend at Baylor in Boone Powell, Jr. He would always show Mr. Powell the board scores of the residents. One year, the Baylor housestaff was in the 99th percentile nationwide on the internal medicine board examination, making Dr. Fordtran proud and impressing Mr. Powell greatly. The match list for residents was also becoming more favorable, and this added to the interest of Mr. Powell and the administration.

At a retreat at Horseshoe Bay, medical education was discussed. Drs. Fordtran, Jerome Arndt from radiology, and Ronald Jones, chief of surgery, attended. They presented information to the administration that showed that the future staff of Baylor would be populated by physicians who had trained at the institution. Sixty-seven percent of the residents were staying at Baylor. They pointed out that if the teaching programs at Baylor were mediocre, then the future medical staff would become mediocre. The administration committed to making the teaching programs at Baylor the best that they could be. The internal medicine program was allowed to expand by 50% in 1983. With the emphasis on teaching from members of the internal medicine department and support from the administration, both the medical student program and the residency program were improved.

Dr. Fordtran continued to try to get general internists involved in teaching rounds. Because many of the subspecialists were receiving a salary or office space from Baylor, he was able to secure funds to pay the internists for attending rounds because they had to be away from their office, where rent and overhead costs continued.

Dr. Fordtran had to continue to fight for the teaching program. For example, as the emergency department grew in the

Figure 12. Dr. Marvin J. Stone, director of Baylor Sammons Cancer Center and chief of oncology, in charge of junior medical students since 1983.

1990s, the outpatient clinic where residents take care of medically indigent patients needed to be displaced. The administration proposed a site outside of the hospital. Dr. Fordtran vigorously opposed that move because it would take the residents outside the building and would send a signal that the residents' clinic was not important enough to remain in the main building. He lobbied for the clinic to remain within the hospital. An excellent clinic was therefore designed on the second floor of Hoblitzelle Hospital. The space is very functional, and although it is physically more distant from the housestaff quarters, the new site has been well received by the housestaff and patients. When Dr. Mark Armstrong became the Baylor Professor of Internal Medicine in 1995, he formalized an outpatient attending format. The clinic now has consistent medical staff attending coverage provided by Drs. Armstrong, Paul Muncy, Sue Bornstein, Holly Lemons, and Kyle Lloyd.

Education of medical students

When Dr. Fordtran was chosen to be the chief of internal medicine, he was approached by Dr. Frederick Bonte, the dean at UT Southwestern, regarding the education of medical students at Baylor. For many years, medical students had been coming to Baylor for a third-year rotation in internal medicine. Although this was felt to be a good rotation, Dr. Bonte wanted it to be better. He offered to make Dr. Fordtran an assistant dean at the medical school if he would improve the education of medical students at Baylor. Dr. Fordtran accepted this challenge and proceeded to institute several changes.

One of the most important changes he adopted was to have daily meetings with the medical students. Initially he was responsible for most of these meetings, but later he had the students meet with other staff members, including Drs. Emmett, Stone, Hyland, Stephen Johnston, and Cristie Columbus. Because the Baylor rotation is significantly different from the Parkland rotation, Dr. Fordtran felt that there needed to be a unique program at Baylor for medical students. The students seemed to like the daily meetings, as it gave them a chance to discuss cases with outstanding clinicians. Because the program was so popular, many of these students applied to be internal medicine residents at Baylor. Dr. Dan DeMarco and Dr. Ellen Mitchell were two of the first students from UT Southwestern who participated in this program, and both chose Baylor for their residencies. Having an outstanding medical student program has continued to be important in attracting some of the best UT Southwestern graduates. Dr. Stone *(Figure 12)* was asked to take charge of the third-year rotation early in Dr. Fordtran's tenure. He has done an outstanding job for 20 years.

Dr. William Sutker, director of medical education

Dr. William Sutker *(Figure 13)* finished his fellowship in infectious diseases at the same time that Dr. Tompsett retired as chief of internal medicine and that Dr. Reese resigned as director of medical education and chairman of the medical education committee. Dr. Tompsett arranged for Dr. Sutker to succeed Dr. Reese in both positions, starting in July 1979 when Dr. Fordtran arrived at Baylor. In these positions, Dr. Sutker had responsibility for the quality of medical education of all Baylor residency and fellowship programs. He was also responsible for all administrative issues concerning the residents and fellows. Over the many years that Dr. Sutker has functioned in this role, he has greatly improved all of the training programs that were designed primarily for teaching, and he withdrew approval of Baylor programs that "used" rather than "taught" the residents or fellows. He is a strong and ongoing advocate of quality medical education at Baylor.

Figure 13. Dr. William Sutker (third from the left), director of medical education and chairman of the medical education committee since 1979, with internal medicine residents.

Unassigned patients

In the early 1980s, emergency department use was expanding. The burden of the unassigned patients who presented to the emergency department and then had to be admitted was becoming heavier for the internists. All of the internists, both the subspecialists and generalists, were on a rotational list to admit those patients who needed admission but did not have a private physician at Baylor. On some days, the physician on call would admit 10 patients or more. These patients had complex medical problems; some had not received any medical care for years. Upon the patent's discharge from the hospital, the internist was responsible for posthospital care. In order not to be accused of abandoning the patient, the internists would either have to see these patients in their offices or write them a formal discharge letter. The internists became unhappy as the burden increased. The subspecialists did not want to admit patients whose primary problem was not within their areas of expertise. This issue was discussed at multiple meetings of the medical advisory committee, and the internists asked the administration to find an alternate method of caring for these patients or to restrict further expansion of the emergency department.

Robert Hille was the administrator at Baylor at this time, and he contacted Dr. Leonard Riggs, a physician who was responsible

for setting up the emergency department physicians in the 1970s. Dr. Riggs hired a group of general internists to admit all unassigned medical cases from the emergency department. This group was financially subsidized by the hospital because many patients were indigent and had no funding for medical care. Dr. Irving Prengler, a private internist at Baylor, organized a coalition of recent graduates from internal medicine programs. Over the next several years, the Texas Primary Care (TPC, as it became known) physician group attracted permanent members to its group, and it continues to care for the unassigned emergency department patients. This has been a very popular decision with all members of the medicine department. Now the TPC physicians admit the unassigned patients, and the subspecialists see these patients in consultation. This is a much more palatable practice for the generalists and for the subspecialists.

Organ transplantation

Dr. Fordtran had a close friendship with Dr. Thomas Starzl, the leading organ transplant physician in the country. Dr. Starzl and Dr. Fordtran were instrumental in establishing the kidney and liver transplant center at Baylor (18). This center has added to the prestige of Baylor and continues to be very successful.

Staffing of satellite hospitals

In early 1980s, Boone Powell, Jr., advocated that Baylor develop a hospital system rather than remain a single-hospital campus. The rationale for a system was based on 4 premises: 1) acquisition of small community hospitals by larger hospitals or hospital chains was inevitable; 2) "certificate of need" requirements (which were then in existence) would prevent Baylor from later entry into smaller communities; 3) a hospital system would reduce costs by allowing Baylor to better negotiate with insurance companies; and 4) a hospital system would raise the profile of Baylor in suburban communities. In short, Baylor needed to develop a hospital system to protect BUMC.

As the developing Baylor system accumulated smaller hospitals, there was an urgent need to staff those hospitals with excellent physicians, perhaps most particularly in internal medicine. Dr. Steve Johnston, who was in his cardiology fellowship at Baylor, suggested that Baylor recruit Drs. Larry Jinks and Glenn Ledbetter. The idea was a good one, except that both physicians already had plans to practice elsewhere. Dr. Johnston, one of the world's best recruiters, said not to worry, and he proposed a strategy.

How these recruitments proceeded is described in the following reports from Dr. Jinks and Dr. Ledbetter.

> *From Dr. Jinks:* I was making rounds with Sheff Ollinger one day during my final year at BUMC when my beeper went off. I didn't recognize the number on the beeper, but I called and a pleasant voice answered "Boone Powell's office." Nervously I told her who I was, and she told me that Mr. Powell wished to speak to me, right now. Now, I thought! What could I have done wrong? I told Dr. Ollinger what had happened, and he stroked his gray beard and said "I don't think anyone has ever been in that kind of trouble before!"
>
> As I walked to Mr. Powell's office, all of the deeds and misdeeds of my residency flashed before me. As I arrived in his office, my heart absolutely sank, because through the door, I saw Mr. Powell and Dr. Fordtran. What was the chief of medicine doing here? I was 6 months away from moving to the mid-cities to start my practice and thought I was about to lose it all. I was escorted into the office and over the next hour, I was introduced to Baylor's grand plan. I have never been so flattered in all my life. I was actually to be a part of Baylor's future! Fondly, I often reflect upon that day and thank God for the decisions made thereafter. Living in Ennis has been good for my family, and I will always thank BHCS for bringing me here.
>
> *From Dr. Ledbetter:* In July 1983, I began an internal medicine internship at Baylor. I enjoyed teaching medical students and interns, and in my last year of residency I was contacted by one of my medical school mentors at the Louisiana State University School of Medicine in Shreveport who asked me to join the faculty as an associate professor. I felt that was the direction I was to pursue. However, Drs. Johnston and Fordtran and Mr. Powell convinced me to consider relocation to rural Ellis County. After discussing this possibility with Drs. James Boone and John Bousquet, who were 1 year behind me in the internal medicine training program, the three of us agreed to move to Waxahachie and establish Ellis County Diagnostic Clinic in association with BHCS. I am extremely grateful for Baylor's vision for the new Baylor Hospital in Waxahachie and for being directed to this community.

Several years later, there was a decision to expose Baylor residents to the practice of internal medicine in a rural setting, where subspecialists are not usually readily available. The Ledbetter group at Waxahachie accepted this challenge, and for many years now all medical residents at Baylor have spent 1 month in Waxahachie. This outstanding and popular experience has resulted in increased numbers of our graduates choosing to work in rural communities, and it has allowed Dr. Ledbetter and his colleagues to pursue their love of teaching.

BUMC's fellowship programs, as well as its residency programs, have provided medical staff to community hospitals within our system, as is evident from the following report.

> *From Dr. James Weber:* Near the end of my fellowhip in gastroenterology at BUMC, I accepted an opportunity to start up a gastroenterology program at a Baylor facility in Grapevine, where Dr. Preston and Dr. Demartini were successfully practicing internal medicine, having themselves just completed their residencies at Baylor. In 1992, I joined the staff of Baylor Medical Center at Grapevine, as the only full-time gastroenterologist dedicated to that hospital, and became the director of the first GI lab. Within 3 years, we had 3 practicing gastroenterologists in the group, and Baylor built a new larger GI lab to accommodate us. At present, we have 6 gastroenterologists dedicated to Baylor in Grapevine. Other specialists such as Dr. Phil Hecht, who completed residency and cardiology fellowship training at Baylor, also joined the staff and became very active in developing cardiology and other specialty service lines at Baylor Grapevine. As the needs of the area grew, so did Baylor's presence in Grapevine, with increasing facilities, equipment, and technologic advances, as well as many more top-quality primary and specialty physicians joining our medical community. Our once-small community hospital has this year opened a new bed tower that will add nearly 100 inpatient beds, expanded services to include cardiothoracic surgery and neurosurgery, and yet another new state-of-the-art GI lab.

The nursing service

Dr. Fordtran was a strong supporter and defender of the nursing service at Baylor. He insisted that all personnel within the hospital, especially the nurses, be treated with respect and professionalism. He developed a close relationship with the nursing administration and invited one of the nursing administrators to attend the monthly medical advisory committee meetings. This allowed nursing concerns to be discussed with physicians. If physicians did

not respect nurses or were rude to them, he had no hesitation in addressing the physician directly. This resulted in a better working relationship between nurses and physicians. Dr. Fordtran's ideas helped formulate a change in the medical staff bylaws to improve morale among Baylor nurses. Upon his retirement he was awarded the title of "Honorary Registered Nurse" by the nursing staff in recognition of his support for nursing excellence and for promoting positive nurse-physician relations.

The conclusion of Dr. Fordtran's tenure

Many controversial decisions were made by Dr. Fordtran and the medical advisory committee, mainly related to medical education, hospital-based status of physicians, hospitalists, ER call, and the subspecialties. For example, towards the end of his tenure, Dr. Fordtran believed that forces were at play that would effectively separate cardiology from internal medicine. He fought hard to avoid such a separation because he thought it would be detrimental to internal medicine, to the teaching service, and to cardiology itself. Despite the controversy, the department remained cohesive. All divisions remained a part of internal medicine, including neurology and dermatology, and the teaching program prospered.

Dr. Fordtran thought that division heads should retire at the age of 65. This policy led to some important shifts in chiefs. Dr. Sheff Olinger was replaced by Dr. Gary Tunell in neurology. Dr. Coleman Jacobson was followed by Dr. Alan Menter in dermatology. When Dr. John Hyland became 65, Drs. John Schumacher and Kevin Wheelan were appointed co-chiefs of cardiology. When Dr. Fordtran reached the age of 65, he gave up his position as chief of internal medicine, although he continued to serve as president of the Baylor Research Institute until 1999.

Acknowledgments

Mrs. Henry Winans, Jr., Mr. David Hitt, and Drs. John Binion, Jack Edwards, Jabez Galt, Arvel Haley, E. R. Hayes, Cary King, LeRoy Kleinsasser, Don Seldin, and Elgin Ware were interviewed about events at Baylor prior to 1957. In preparing the history of the eras of Drs. Fordtran and Emmett, Dr. Armstrong relied on interviews with them and with other medical staff members, as well as on detailed minutes of the medical advisory committee meetings. These minutes were also used by Drs. Armstrong and Emmett in preparing reports about the various divisions of the internal medicine department. In most instances, comments about the divisions were reviewed by several members of the various divisions. Drs. Dan DeMarco, Jack Hyland, Russell Martin, Paul Neubach, Dan Polter, Marvin Stone, William Sutker, Gary Tunell, and David Winter read the entire manuscript for accuracy and balance.

1. Beeson PB. One hundred years of American internal medicine. A view from the inside. *Ann Intern Med* 1986;105:436–444.
2. Stevens R. Issues for American internal medicine through the last century. *Ann Intern Med* 1986;105:592–602.
3. Means JH. *The Association of American Physicians: Its First Seventy-five Years*. Boston: Association of American Physicians, 1961.
4. Osler W. President's address. *Transactions of the Association of American Physicians* 1895;10:11–13.
5. Fordtran JS. An ASCI tradition. Presidential address. *J Clin Invest* 1977;60: 271–275.
6. Osler W. Internal medicine as a vocation. In *Aequanimitas*, 3rd ed. Philadelphia: P. Blakiston's Son & Co, 1932:133–145.
7. Bean WB. Occasional notes. Origin of the term "internal medicine." *N Engl J Med* 1982;306:182–183.
8. Durant TM. *The Days of Our Years: A Short History of Medicine and the American College of Physicians*. Madison, NJ: Wyeth Laboratories, 1965.
9. Morgan WG. *The American College of Physicians: Its First Quarter Century*. Philadelphia: American College of Physicians, 1940.
10. Rosenow EC Jr. *History of the American College of Physicians: Executive Perspectives 1959–1977*. Philadelphia: American College of Physicians, 1984.
11. Anderson RJ. Subspecialization in internal medicine: a historical review, an analysis, and proposals for change. *Am J Med* 1995;99:74–81.
12. Howell JD. The invention and development of American internal medicine. *J Gen Intern Med* 1989;4:127–133.
13. Peitzman SJ. When did medicine become beneficial? The perspective from internal medicine. *Caduceus* 1996(Winter);12:3944.
14. Fordtran JS. Medicine in Dallas 100 years ago. *BUMC Proceedings* 2000;13: 34–44.
15. Moursund WH. *A History of Baylor University College of Medicine 1900–1953*. Houston: Gulf Printing, 1956.
16. Stone CT. Internal medicine. *Tex Med* 1967;63:74–77.
17. Tributes to Benjamin A. Merrick, MD. *BUMC Proceedings* 2000;13: 99–101.
18. Starzl TE. *The Puzzle People. Memoirs of a Transplant Surgeon*. Pittsburgh: University of Pittsburgh Press, 1992.

Other historical sources consulted

Binion J. An oral biography of Paul Jasper Thomas, MD.

Bradford B. Baylor staff honors doctor. *Dallas Morning News*, September 21, 1955.

Chapman JS. *The University of Texas Southwestern Medical School. Medical Education in Dallas 1900–1975*. Dallas: Southern Methodist University Press, 1976.

Dr. H. M. Winans, 71, dies in Dallas. *Dallas Morning News*, March 14, 1965.

Dr. Winans dies at 71; physician, educator and soldier. *Dallas Morning News*, March 16, 1965.

Draper WH. On the relations of scientific to practical medicine. *Transactions of the Association of American Physicians* 1888;3:1–8.

Fitzgerald FT. The case for internal medicine. *N Engl J Med* 1993;328:654–656.

Kahn RJ. Echoes of the past: problems and progress in internal medicine. *ACP Observer* 1991(Jan):1–9.

King LS. Medicine in the USA: Historical vignettes. XVI. Clinical science gets enthroned. Part II. *JAMA* 1983;250:1847–1850.

LaCombe M. What is internal medicine? *Ann Intern Med* 1993;118:384–387.

Langdon LO, Toskes PP, Kimball HR. Future roles and training of internal medicine subspecialists. American Board of Internal Medicine Task Force on Subspecialty Internal Medicine. *Ann Intern Med* 1996;124:686–691.

Maulitz RC. Grand rounds: an introduction to the history of internal medicine. In Maulitz RC, Long DE, eds. *Grand Rounds: One Hundred Years of Internal Medicine*. Philadelphia: University of Pennsylvania Press, 1988:3–13.

Osler W. The hospital as a college. In *Aequanimitas*, 3rd ed. Philadelphia: P. Blakiston's Son & Co, Inc, 1932:313–325.

Rhoads PS. A century of progress in internal medicine. *Proceedings of the Institute of Medicine of Chicago* 1974;30:51–61.

Roberg N. Internal medicine in the 1930s. *JAMA* 1988;260:3645–3646.

Slepicka L. Curious mind led doctor to people. *Dallas Morning News*, March 15, 1965.

Smith LH Jr. Presidential address. *Transactions of the Association of American Physicians* 1976;89:1–9.